## RIGHTS AND RESPONSILBILITEES FOR QUALIFYING INDIVIDUALS

**RIGHTS**

You have the right to:

Apply for assistance, and, if found ineligible, reapply at any time. Have any person, not to exceed 3, participate in the interview for determination of eligibility. Be protected against discrimination on the grounds of race, creed, or national origin by Title VI of the Civil Rights Act of 1964. Have any information given to the agency kept in confidence. Be informed of information needed to determine Family Assistance/Medicaid eligibility. Withdraw from the assistance program at any time. Receive assistance, if found eligible.

**RESPONSIBILITIES**

**You** must:

Provide the county department of social services, as well as state and federal officials, upon request, the information necessary to determine eligibility. Report to the county department of social services any change in your situation within 10 calendar days of knowing the change (5 calendar days for Special Assistance). Report to the county department of social services the receipt of assistance which you know is incorrect. Certify by signing this application that all information that you have provided, concerning your situation and/or that of all the persons for whom you are making an application, is a true and complete statement of facts according to your best knowledge and belief.

**RESIDENCE**

**I** hereby certify that I and all the persons for whom I am making an application are living in North Carolina with the intention of remaining.

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**MEDICAL RECORDS**

**I** understand that my medical and financial records must be made available to the agency and the state by any provider from whom I have received **Medical Assistance Program** services. I hereby agree to the release of those records by those providers when requested by the agency and the state

**ASSIGNMENT OF RIGHTS**

**I** understand that by accepting Medical Assistance under any aid program/category, I agree to give back to the state any and all money that is received by me or anyone listed on this application from any insurance company for payment of medical and/or hospital bills for which the Medical Assistance program has or will make payment. In addition, I agree that all medical payments or medical support paid or owed due to a court order for me or anyone listed on this application must be sent to the state to repay past or current medical expenses paid by the state. This includes insurance settlements resulting from an accident. I further agree to notify the county department of social services if I or anyone listed on this application is involved in an accident.

**SOCIAL SECURITY NUMBERS**

I understand that I must furnish all social security numbers used by me and/or anyone listed o n this application to determine my eligibility for assistance. I alsounderstandthesesocialsecuritynumberswillbeused.inmatchinginformationwiththeSocialSecurityAdministration (SSA), Internal Revenue Service (IRS), Employment Security Commission (ESC), Department of Transportation (DOT), out of state welfare and ESC agencies, and any other agencies, when applicable. If I do not want these social security numbers used in the matches, I understand that I have the right to withdraw my application or have my assistance terminated.